General HIPAA

About HIPAA

Q. If a claim is error free is it HIPAA compliant?

A. Not necessarily. HIPAA compliance regulates the format of the claims submission as well as the rules of submission, such as those pertaining to privacy and security. A claim can pass the syntax testing (i.e. Claredi and Validator) and still contain errors in the data submitted or the business requirements for each payer.

Q. Is sending data on a disc considered an electronic transaction?

A. Yes

Q. Does the law require physicians to buy computers?

A. No, there is no such requirement. However, more physicians may want to use computers for submitting and receiving transactions (such as health care claims and remittances/payments) electronically. The Administrative Simplification provisions of the HIPAA law were passed to support the health care industry. HIPAA law requires that all transactions submitted electronically comply with the standards. Providers, even those without computers, may want to adopt these standard electronic transactions, so they can benefit directly from the reductions in cost. This is possible because the HIPAA law allows providers and health plans, to contract with clearinghouses to conduct the standard electronic transactions for them.

Q. Does MDCH expect that the CEO will certify each data submission?

A. MDCH has not yet developed guidelines for that process. It is not required until August 2003.

Q. What is available to help with HIPAA implementation?

A. Testing is currently available. MDCH has contracted with Claredi Inc., to test and certify transactions for HIPAA compliance. Blue Cross Blue Shield of Michigan has contracted with Foresight for the same purpose. Each mental health PHP and Medicaid Health Plan will be included in this contract and is strongly encouraged to take advantage of this no-cost opportunity. Training is available through Michigan Virtual University at http://healthcare.mivu.org/. These are on-line courses and are available via the Internet 7 days a week, 24 hours a day.

Q. Will date of service determine the claim format after October 1, 2002?

A. No, the date of submission will determine the format after October 1, 2002. You must use the new format for all claims submitted after Oct 1, 2002, despite the date of service.

The schedule for Nursing Facilities implementation is contained in the L-02-25 letter issued by MDCH. This Provider letter addresses the Nursing Facilities delay in implementation of the 837 I format. A copy of this letter is available at http://www.michigan.gov/documents/NF_Sept_Numbered_letter_L-02-25_42268_7.pdf.

The schedule for the implementation of the other transactions is available on the Michigan Virtual University website at http://healthcare.mivu.org/. These are on-line courses and are available via the Internet 7 days a week, 24 hours a day.

Q. Does the law also require Medicare claims to be submitted electronically after October 2003?

A. HIPAA Administrative Compliance Act (ASCA) prohibits Health and Human Services (HHS) from paying Medicare claims that are not submitted electronically after October 16, 2003, unless the Secretary of HHS grants a waiver from this requirement. It further provides that the Secretary must grant such a waiver if there is no method available for the submission of claims in electronic form or if the entity submitting the claim is a small provider of services or supplies. Beneficiaries will also be able to continue to file paper claims if they need to file a claim on their own behalf. The Secretary may grant such a waiver in other circumstances. CMS will publish proposed regulations to implement this new authority.

Q. Is it true that HIPAA wants the states to give providers one unique number that they can use to bill both Medicare and Medicaid. Is Michigan doing this?

A. Currently Michigan does not have any plans to use the same ID number for both Medicare and Medicaid. Medicare's website is indicating that a Notice of Proposed Rule Making (NPRM) will be coming out recommending the adoption of a national provider identification number which would cover many professions and facilities. This would be done centrally and would apply to all payers, not just Medicare and Medicaid.

Q. Whose responsibility is it to make a provider compliant?

A. Provider is responsible for the data he transmits. The vendor dealing with the provider is responsible for format and compliance. They both will need to work with each other to ensure compliancy. However it will be the ultimate responsibility of the provider to transmit HIPAA compliant claims.

HIPAA Implementation Guide

Q. Where are the implementation guidelines for HIPAA transactions?

A. Michigan will follow the national HIPAA implementation guide found at http://www.wpc-edi.com/hipaa. There will be no Michigan-specific implementation guidelines for HIPAA transactions but MDCH has developed short Data Clarification Documents that can be found on the MDCH web site at www.michigan.gov/mdch.

- Click on "Providers" which is found on the left side of the screen
- Click on "HIPAA Implementation" which is the eighth quick-link on the right hand side of the page.
- Click on "Data Clarification Documents" which is in the middle column.

Q. Please clarify the use of the Implementation Guide and the Clarification Documents.

A. MDCH is using the Implementation Guide (IG) of May 2000 (not the addendum). There are MDCH Clarification Documents on the web for 837 claims and encounters (professional, institutional and dental) that are to be used with the IG, not as a substitute. These are companion documents that clarify content needed by MDCH. Blue Cross Blue Shield of Michigan (BCBS) also has companion documents on their website to specify content needed for BCBS claims.

Q. Our organization is planning to send the Tax ID in the Billing Provider ID field. Per the implementation guide, the Billing Provider ID is, the EIN, SSN or National Provider ID. Since we don't have a National Provider ID yet, we're currently left with using either the EIN or SSN. Since the SSN applies to individuals and we're an organization, we'll need to use the EIN. Is that a correct interpretation of HIPAA implementation guide?

A. The "Employer ID requirements" (referencing HHS' Standard Unique Employer Identifier Final Rule, published May 31, 2002) relates to identifying employers on standard transactions. While an EIN can be used in various situations on those transactions to identify a provider, the Final Rule concerns itself only with identifying an employer. Use the Tax ID in the Billing Provider ID field NM109 (page 86) with the '24' qualifier indicating Employer's ID number.

Q. What are the implementation guide specifications regarding transaction interchanges in "real-time?" It is important for the healthcare industry to standardize real time versus batch time in order to facilitate the communication between providers, payers and intermediaries, etc?

A. The HIPAA implementation guide states the term "Real-time" doesn't imply a set response time. Real-time means, a submitter makes a "connection", submits the interchange and waits for a response without breaking the connection. Monitoring and managing turn-around time is easy when the provider is connected directly, but difficult when the inquiry is from a clearinghouse, since there is no way to know or control the throughput of the entire system. The 270/271, 278, and 276/277 guides all state that the real-time response should be delivered within 60 seconds. The 270/271 and 278 guides goes further, stating that the response, a 997, or a TA1 must be delivered within the given time frame. It also limits the number of inquiries on a real-time 270/278 to one—there is no such limitation in the 276 guides.

Q. Does anyone know the history behind how the "Standard" section of the Implementation Guides was developed and eventually turned into the "Implementation" section of the Guides?

A. The "Standard" represents the transaction in its pure, global form, if you will. It reflects all the components that are valid for all uses of the transaction set. The "Implementation" is a road map for how that standard is to be applied to a particular business purpose. Case in point is the 837. As we know, there are three implementations of the 837 mandated under HIPAA -- Professional, Institutional and Dental claims and encounters. The "Implementation" is different for all three, but you'll see that the "Standard" is the same for all, as those are the building blocks of the 837 transaction set.

HIPAA Enforcement

Q. What action will be taken against HIPAA covered entities that have not submitted extension requests by October 15, 2002?

A. The Administrative Simplification Compliance Act (ASCA) permits the Secretary of HHS to exclude noncompliant covered entities from the Medicare and Medicaid program between October 16, 2002 and October 16, 2003 if they have not submitted an extension request

Q. Exclusion from Medicare or Medicaid is a severe penalty. Would there be any extenuating circumstances?

A. Yes. Consideration would be given to whether excluding a specific provider could adversely affect beneficiaries' access to care or patient safety.

Q. Who will enforce the HIPAA standards?

A. Department of Health and Human Services (HHS) has determined that Center for Medicare and Medicaid Services (CMS) will have responsibility for enforcing the transactions and code set standards, as well as security and identifiers standards when those are published. CMS will also continue to enforce the insurance portability requirements under Title I of HIPAA. The Office for Civil Rights in HHS will enforce the privacy standards.

Q. Doesn't the HIPAA law envision HHS providing technical assistance to the industry to help them become compliant?

A. Yes. HHS enforcement strategy will concentrate on achieving voluntary compliance through technical assistance. Penalties would be imposed as a last resort.

Q. What will the enforcement process look like?

A. The enforcement process for HIPAA transactions and code sets (and for security and standard identifiers when those are adopted) will be primarily complaint-driven. Upon receipt of a complaint, CMS would notify the provider of the complaint, and the provider would have the opportunity to demonstrate compliance, or to submit a corrective action plan. If the provider does neither, CMS will have the discretion to impose penalties.

Q. What kinds of penalties could be imposed for non-compliance after October 16, 2003 if they have submitted an extension request?

A. The original HIPAA legislation permits civil monetary penalties of not more than $100 for each violation, with a cap of $25,000 per calendar year. (Much larger penalties are provided for certain wrongful disclosure of individually identifiable health information). Thus, the ASCA penalty is for failure to submit an extension request, and it applies only to Medicare and Medicaid providers, while the HIPAA penalty is for noncompliance, and is generally applicable. Medicare providers could be both excluded and fined, while non-Medicare covered entities would be subject only to the civil monetary penalties.

Q. Will these penalties be imposed on all covered entities that did not submit requests?

A. No. The process leading to these penalties would be initiated primarily in response to an external complaint filed against a covered entity. Once a complaint is received, the entity will have opportunities to avoid penalties by demonstrating compliance, showing how they will achieve compliance by submitting a corrective action plan, or, for ASCA purposes, showing that they had submitted an extension request. Only when an entity does none of these things would consideration be given to invoking civil monetary penalties or excluding a provider from Medicare or Medicaid

Q. How would someone file a complaint against a covered entity?

A. CMS will develop a web-based complaint management process, and will provide information on this process as part of our HIPAA outreach activities.

Q. How will CMS publish details about how this process will work?

A. CMS intends to develop regulations that would set out how the enforcement process will operate and how penalties will be imposed.

Q. What should a covered entity that did not submit an extension request do now?

A. They should come into compliance as soon as possible, and should be prepared to submit a corrective action plan in the event a complaint is filed against them.

Q. Will a covered entity that was not in existence prior to October 15, 2002 be subject to these penalties?

A. A newly formed covered entity could utilize a clearinghouse or compliant vendor to become compliant at the time it comes into existence. If the entity is not able to achieve compliance immediately, good faith efforts could be taken into account in the event a complaint is filed. Also, in the event of a complaint, the entity could submit a corrective action plan.

Transaction Extension Deadline

Q. Why should I request an extension for achieving compliance with the HIPAA transaction standards?

A. If you did not request an extension, your agency must have been in full HIPAA compliance for transaction and code set standards as of October 15, 2002. The compliance plan must have been submitted no later than October 15, 2002.
If you did request an extension, you can phase in the HIPAA requirements by October 1, 2003. You will have ample opportunity to test your system changes and modify them as necessary during this extension period. MDCH has filed and received an extension.

Q. How do I file for an extension?

A. The requirement was that your extension application must have been received by the Department of Health and Human Services (DHHS) no later than October 15, 2002.

Q. Should my providers request an extension?

A. The deadline for extension requests was October 15, 2002.

Q. Does the ASCA extension apply to the HIPAA privacy standards?

A. No, the compliance date for the privacy standards is still April 14, 2003 or, for small health plans, April 14, 2004.

Q. Do all covered entities automatically get an extension?

A. No. Each covered entity must have submitted a compliance extension plan to the Department of Health and Human Services (HHS) no later than October 15, 2002 to get an extension.

Q. What will be the impact of the one-year extension?

A. The extension will allow all covered entities time to build, test and implement the new Electronic Transaction and Code sets required by HIPAA.

Q. Regarding the letter dated May 2002 and the HIPAA transaction sets. We have filed an extension form with Medicare for one year. Does this same extension apply to Medicaid, and give us a Medicaid extension?

A. Extensions should be filed with CMS and are good until October 2003 when all transaction sets must be implemented. The extension is with CMS rather than specifically to Medicare or Medicaid.

Q. We having been submitting paper claims to Medicaid for speech therapy and plan on continuing to do so: Here is our question: What are the changes we need to make to our release of information form? Also, Do we need to file for an extension if we are planning on continuing to file on paper?

A. The first question deals with HIPAA privacy and security. The MDCH privacy team is currently researching these questions and will respond when solutions are available. For the second question the answer is "NO." HIPAA rules do not apply to paper transactions.

Q. We have already filed our ASCA extension for both the Hospital & our Network Physician Practices. I have just learned that there is a possibility of a new Group forming, but the information needed for ASCA will not be available until after the October 15th deadline. How does one handle this type of situation? Does the Group have to submit paper claims?

A. Use the best available information now and file for the extension. For the medicare ID field use New Program or Applied For or Pending or anything else to indicate the status.

Q. Must every employer/plan sponsor independently submit an ASCA compliance plan to obtain the extension? Our company is a third party administrator (TPA) for a large number of employer-sponsored health plans under ERISA. They all have the same implementation plan. May we file one plan as a TPA for all these plans?

A. First, determine whether the plans are "small health plans" for purposes of HIPAA. If they are, they already have a compliance date of October 16, 2003, and are not eligible to file for a further extension. Many ERISA plans will meet this definition. For those plans that are not "small health plans," the obligation to file a compliance plan rests with the plan, not the TPA. The use of the same TPA does not make two or more plans "related entities." However, the TPA may submit the ASCA compliance extension plans on behalf of the employer/sponsor.

Q. The HIPAA Newsletter states that "Effective October 1, 2002, the MDCH will no longer accept any of its current proprietary electronic claims formats". The question is, will Hospitals that will file for the one year extension, be allowed an additional year to submit in the current format, while they convert their systems to support the X12N 837 format?

A. For the institutional inpatient and outpatient hospitals that have filed for the ASCA extension can continue to send UB-92, EMC version 5.0 until October 16, 2003. For hospitals that provide dental services, dental claims must be submitted using the ANSI X12 837 Dental v 4010 format as of Oct 1, 2002.
Please read the September Numbered Letter L-02-25 for more details. A copy of this letter is available at http://www.michigan.gov/documents/NF_Sept_Numbered_letter_L-02-25_42268_7.pdf.
The schedule for the implementation of the other transactions is available on the Michigan Virtual University website at http://healthcare.mivu.org/. This is an on-line course and is available via the Internet 7 days a week, 24 hours a day.
Changes for October 1 2002 are:
• Dental must submit ANSI X12 837 Dental v 4010
• Michigan Department of Community Health has delayed the implementation of the ANSI ASC X12N 837
Institutional v. 4010 claim transaction for Nursing Facilities from October 1, 2002 to January 1, 2003 to allow additional time for testing.
All other transactions can continue as is, until October 1, 2003, which is the drop-dead date for HIPAA compliancy.
Please read the May L-02-16 and the current September L-02-25 Official Numbered Letter that is on the website at www.michigan.gov/mdch. Go to Providers, HIPAA Implementation and Provider letters. Also review the MDCH implementation chart on the Michigan Virtual University HIPAA Primer course updated as of September 25, 2002. The link to the course directory is http://healthcare.mivu.org/.

Privacy & Security

Q. What about HIPAA security standards?

A. Proposed rules have been released in the form of a Notice of Proposed Rule Making (NPRM). The final rules have not been published in the Federal Register. Once the rules are published they are effective for a limited time. Normal lifespan of a rule is 60 days but varies based on the complexity of the proposed rule.

Q. What will be the effect of the final security rule?

A. The rule requirements will be clarified and redundancies removed. Chain of trust agreements will be necessary in business associate agreements, but not in agreements with other covered entities. The final rule will follow the same philosophy as the proposed rule, only applying to electronically maintained and transmitted health information. It will continue to be technology neutral. Secure encryption technology will be required when transferring protected health information (PHI) specifically across the internet or automated clearinghouse networks. There will be no electronic signature standard, though HHS may later release a separate rule for electronic signatures.

Q. What are the changes we need to make to our release of information form?

A. This question deals with HIPAA privacy and security. The MDCH privacy team is currently researching the answer, and will respond when solutions are available.

Q. Does the ASCA extension apply to the HIPAA privacy standards?

A. No, the compliance date for the privacy standards is still April 14, 2003 or, for small health plans, April 14, 2004.

Miscellaneous

Q. Even though I am a physician, I do not actively engage in the practice of medicine. However, I do provide consulting services to other physicians, such as reviewing medical records for quality assurance purposes, without actually treating the patients. Am I still covered by the Regulations?

A. The circumstances in which physicians are covered by the Regulations are dependent on the activities and functions undertaken by the provider, and not the mere fact that the provider is a physician. Functions that constitute "healthcare" under the Regulations concern the provision of "care, services, or supplies related to the health of an individual." Included may be the following: 1) preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, and counseling, service, assessment or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and 2) sale or dispensing of a drug, device, equipment or other items in accordance with a prescription. The consultation services described above are considered an "indirect treatment relationship," and providers of such services may use and disclose PHI as otherwise permitted under the Regulations and are not required to obtain the patient's consent to use the PHI about the patient for the consultation. The "indirect treatment relationship" exception is covered in more detail in a question below. It is possible that in certain types of consulting relationships a physician may be acting as a "Business Associate," in which case the physician providing such services may be required to enter into a written contract with the healthcare provider regarding the use and disclosure of the protected healthcare information. The function of a "Business Associate" is addressed more thoroughly in another question.

Please note, it would be incorrect to assume that every single health-related function is considered "healthcare" under HIPAA. For example, the procurement or banking

of organ, blood (including autologous blood), sperm, eyes or any other tissue or human product is not considered to be healthcare under the rule and the organizations that perform such activities would not be considered healthcare providers when conducting these functions.